SALUS

DISCLOSURE REPORT REQUEST FORM

Purpose: This form is for requesting a report on protected health information disclosures.

SECTION A: Requester information

Name: _____

Address: _____

Phone Number: _____ Email: _____

Medical Record Number: _____

NOTICE TO REQUESTER: Please read the following notice and provide the information required.

You are entitled to receive a report on the disclosures of your health information made by Salus as part of its operations. The maximum reporting period is up to 6 years prior to the date of your request. The law does not require including disclosures related to the following activities: (a) treatment, payment, or healthcare operations, (b) disclosures addressed to you, your personal representative, or as authorized by you; (c) information that is part of a limited data set disclosed for research purposes or public health activities; (d) for national security reasons, to intelligence agencies, or to correctional institutions regarding persons being held in custody; or (e) incidental to an allowed disclosure.

SECTION B: Requested Disclosure Report

Specify the time period: From: __/__/____ Until: __/__/____

You are entitled to get a free report every 12 months. Salus will charge a reasonable fee per additional report requested during the same 12-month period.

REQUESTER'S SIGNATURE – You are entitled to receive a copy of this request after signing it.

Signature: _____ Date: _____

If this request is filed by a personal representative, please provide the following information:

Name of Personal Representative: _____

Relationship to the Insured Person: _____